DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8661

FILED FEB 24 1944

Registration District No. 374

Primary Registration District No. 6276

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Worth Union
(b) City or town Rural Dallas Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
(Specify whether
In this community Life
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Worth 113
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Parnell Mo.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Evelyn Gail Hemphon

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Sept 10, 1925
(Month) (Day) (Year)

8. AGE: Years 18 | Months 4 | Days 19 | If less than one day ___ hr. ___ min.

9. Birthplace Parnell (City, town, or county) Mo 0 (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name Leo J. Hemphon
13. Birthplace Worth Mo 0 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Muriel Wilgart
15. Birthplace Grant City Mo 0 (City, town, or county) (State or foreign country)

16. (a) Informant Leo J. Hemphon
(b) Address Grant City, Mo

17. (a) Burial (b) Date thereof 1-29-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mount Vernon Cem

18. (a) Signature of funeral director Arch C. Dunlee
(b) Address Grant City, Mo.

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 29
year 1944 hour 11 minute 45 P.M.

21. I hereby certify that I attended the deceased from
Jan 17, 1944, to Jan 29, 1944
that I last saw her alive on Jan 29, 1944
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchial pneumonia	
Due to Influenza	
Due to	

Other conditions
(Include pregnancy within 3 months of death)

Major findings
Of operations

Of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury 0

23. Signature Egbert Crowson (M. D. or other)
Address Parnell Mo Date signed Feb 1

(Licensed Embalmer's Statement on Reverse Side)

1944

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by................

...., Registered Apprentice No...................

working under my personal supervision.

Signed _Arch. C Dunfee_

Licensed Embalmer No. _3252_

P. O. Address _Grant City, M_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
—5-43
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _March_

Registration District No. _374_   Primary Registration District No. _6276_   Registrar's No. _____

1. PLACE OF DEATH:
(a) County _Worth_
(b) City or town _Union Twp Rural_
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community _____ (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State _Mo_   (b) County _Worth_
(c) City or town _Rural_
(If outside city or town limits, write "RURAL")
(d) Street No. _Parnell Mo._
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME _Evelyn G. Herndon_

3. (b) If veteran, name war _____   3. (c) Social Security No. _____

4. Sex _F_   5. Color or race _W_   6. (a) Single, widowed, married, divorced _S_

6. (b) Name of husband or wife _____   6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased _Sept 18 1925_
(Month) (Day) (Year)

8. AGE: Years _18_ Months _4_ Days _____ If less than one day ___ hr. ___ min.

9. Birthplace _Parnell_ (City, town or county)   _Mo_ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _Leo J Herndon_
13. Birthplace _Worth_ (City, town, or county)   _Mo._ (State or foreign country)
14. Maiden name _Muriel Wilgant_
15. Birthplace _Grant City_ (City, town, or county)   _Mo_ (State or foreign country)

16. (a) Informant _Leo J. Herndon_
(b) Address _Grant City Mo._

17. (a) _Burial_ (Burial, cremation, or removal) (b) Date thereof _1-29-44_ (Month) (Day) (Year)
(c) Place: burial or cremation _Mt Vernon Cem._

18. (a) Signature of funeral director _Arch C. Dunfee_
(b) Address _Grant City Mo_

19. (a) _FEB 27-44_ (Date received local registrar) (b) _Arlene Scadden_ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _Jan_ Day _9_
year _1944_ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19___;
that I last saw her alive on _____, 19___;
and that death occurred on the date and hour stated above.
Immediate cause of death _Bronchial Pneumonia_
Due to _Influenza_
Due to _____

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
(Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature _Egbert Crowson_ (M. D. or other)
Address _Parnell, Mo._ Date signed _Feb 1944_

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY (watermark)

Steel